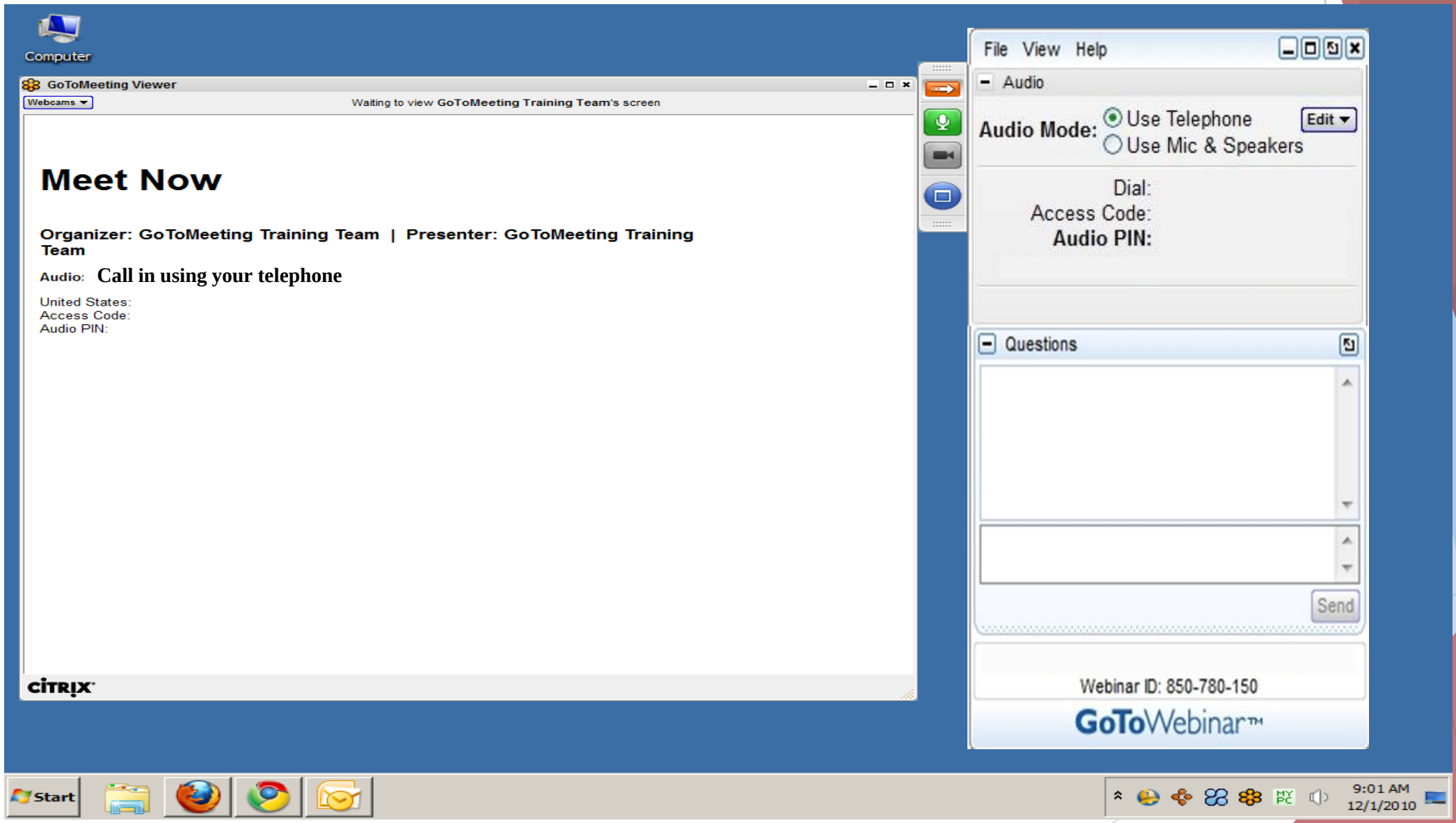
Home Care Services Consumer Protection Act

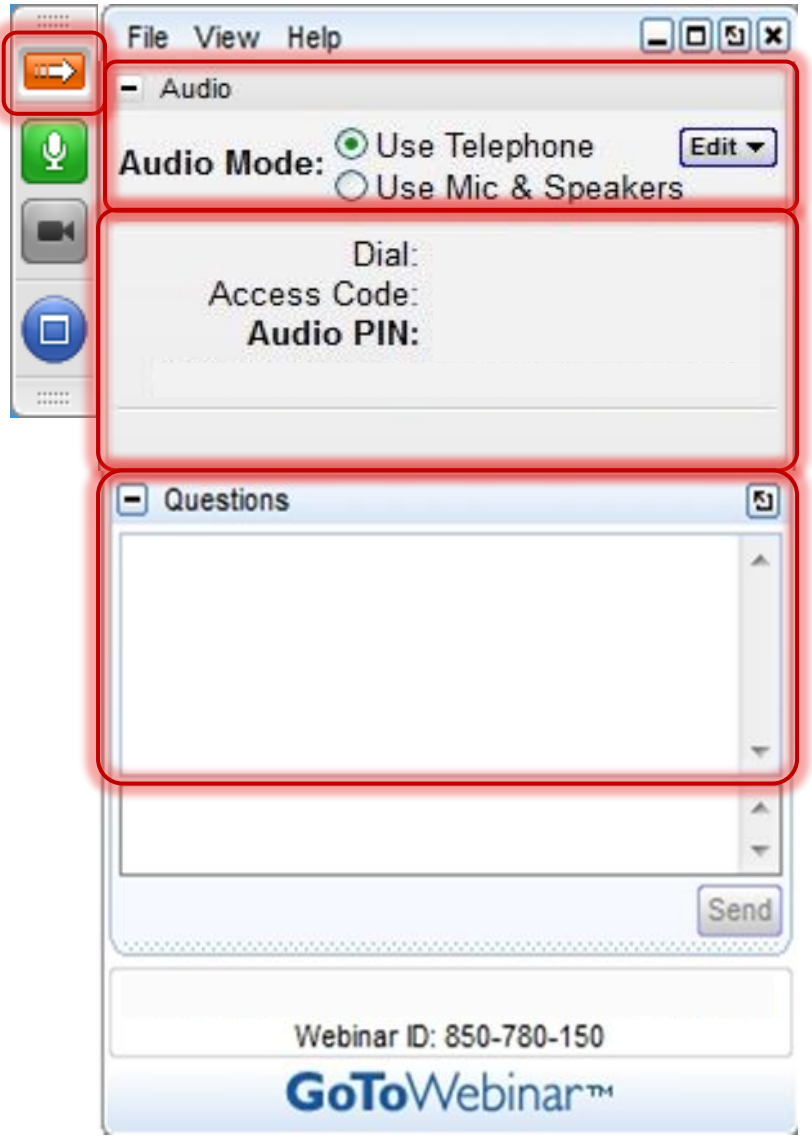
Stakeholders Meeting

March 20, 2015

The GoToMeeting Attendee Interface



GoToMeeting Control Panel



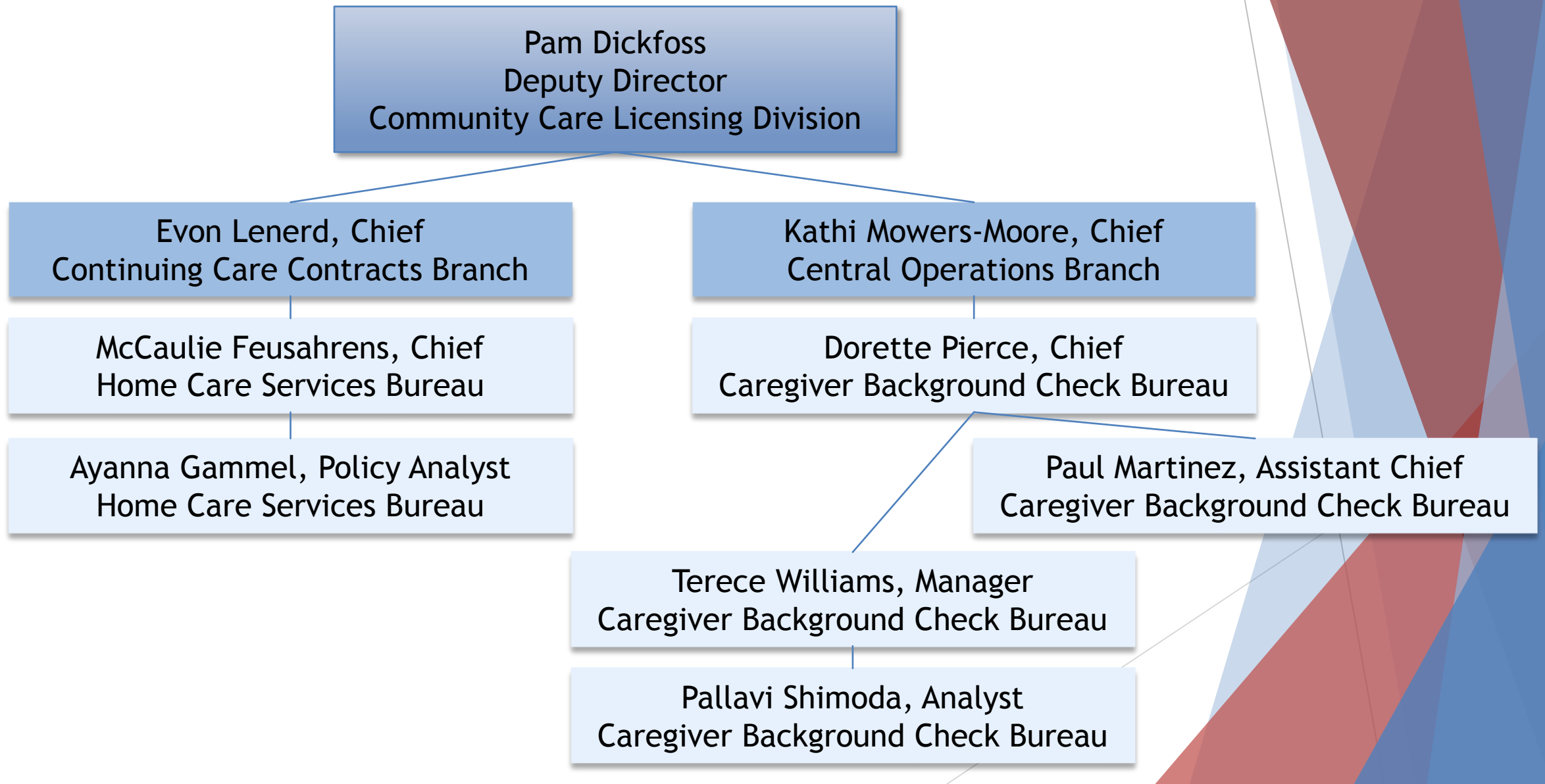
- Expand & collapse your Panel
- Audio: Call in by Conference Call
  - Select “Use Telephone”
  - Dial: 951-384-3421
  - Access Code: 790-388-708
  - Audio PIN: Input your unique PIN
- Chat/Questions: Submit a question or comment and receive responses

Poll

How many HCAs do you project to include on your initial application for a Home Care Organization license?

- 0-10
- 11-30
- 31-60
- 61-100
- 100+

Home Care Services Consumer Protection Act Implementation Team

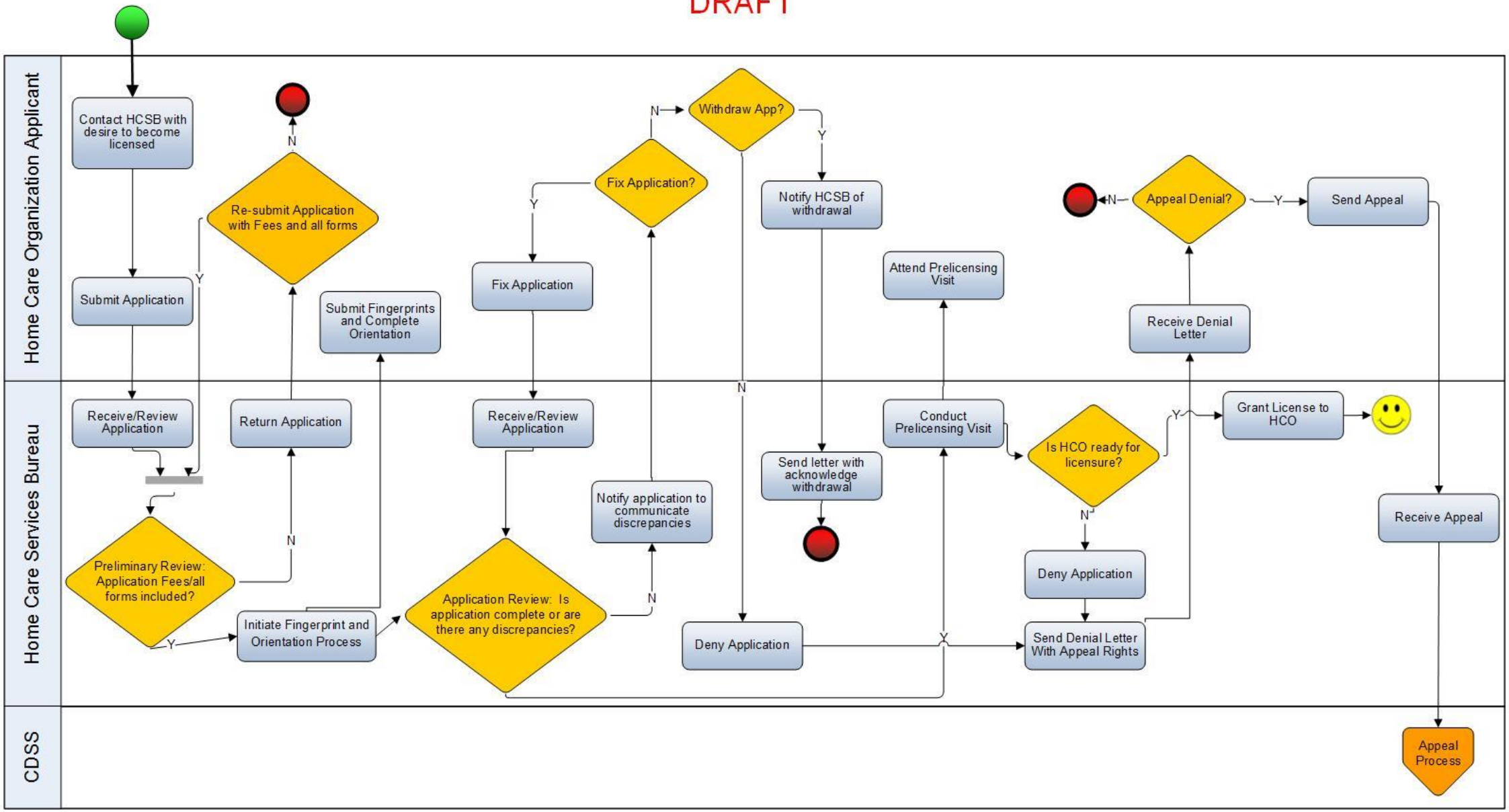


Objectives

- Session One
  - Overview of the background check process
  - Overview of the exemption transfer process
- Session Two
  - Overview of the draft Home Care Organization application package
  - Discussion of the Home Care Organization fee methodology
- Wrap Up/Next Steps

Application Flow for Home Care Organization Applicants

DRAFT



March 20, 2015

DRAFT

APPLICATION FOR A HOME CARE ORGANIZATION LICENSE (HCS 200)

FOR DEPARTMENT USE ONLY

REGIONAL OFFICE: _____

COUNTY: _____ ORG. NUMBER: _____

DATE: _____ ACTION TYPE: _____

REVIEWED BY: _____ ORG. TYPE: _____

REPLY TO:

1. APPLICANT(S) NAME(S) (PLEASE PRINT)

2. REQUESTED ACTION (CHECK ONE)
- ☐ A. INITIAL APPLICATION
- ☐ B. APPLICATION RENEWAL
- ☐ C. CHANGE OF LOCATION
- ☐ D. CHANGE WITHIN CORPORATION
- ☐ E. OTHER (specify)

3. APPLICANT MAILING ADDRESS	CITY	STATE	ZIP CODE	AREA CODE/TELEPHONE ( )

4. APPLICATION FILED BY:
- ☐ A. INDIVIDUAL
- ☐ B. PARTNERSHIP
- ☐ C. NON PROFIT CORPORATION
- ☐ D. PROFIT CORPORATION
- ☐ E. COUNTY
- ☐ F. OTHER PUBLIC AGENCY
- ☐ G. LIMITED LIABILITY CORPORATION

5. HOME CARE ORGANIZATION NAME	EMAIL ADDRESS	AREA CODE/TELEPHONE ( )

6. HOME CARE ORGANIZATION STREET ADDRESS	CITY	COUNTY	ZIP CODE	ALT. PUBLIC TELEPHONE ( )

7. HOME CARE ORGANIZATION MAILING ADDRESS	CITY	STATE	ZIP CODE

8. ADMINISTRATOR OR PERSON IN CHARGE OF ORGANIZATION	TITLE	9. TOTAL # OF AIDES (IF OPERATING)

10. BUSINESS OFFICE HOURS:

11. PROPERTY OWNERSHIP
☐ OWN ☐ RENT ☐ OTHER (SPECIFY)

11A. NAME, ADDRESS AND PHONE NUMBER OF PROPERTY OWNER, IF RENTING OR LEASING:

12. WAS THIS ORGANIZATION PREVIOUSLY LICENSED?
☐ YES ☐ NO
IF YES, ORGANIZATION NAME AND LICENSE NUMBER:

13. ENTER THE INFORMATION BELOW FOR ANY COMMUNITY CARE FACILITY, RESIDENTIAL CARE FACILITY, RESIDENTIAL CARE FACILITY FOR THE ELDERLY, RESIDENTIAL CARE FACILITY FOR PERSONS WITH CHRONIC LIFE-THREATENING ILLNESS, CHILD DAY CARE FACILITY, DAY CARE CENTER, FAMILY DAY CARE HOME, EMPLOYER-SPONSORED CHILD CARE CENTER, OR HOME CARE ORGANIZATION PREVIOUSLY OR CURRENTLY OPERATED. REFER TO INSTRUCTIONS.

	FACILITY NAME AND NUMBER	LICENSING AGENCY NAME
A.		
B.		
C.		
D.		

14. *APPLICANT(S)/LICENSEE(S) RESPONSIBILITIES:*
- a. *I/WE UNDERSTAND THAT IN ADDITION TO COMPLYING WITH THE HEALTH AND SAFETY CODES AND REGULATIONS APPLICABLE TO LICENSING, I/WE MAY BE SUBJECT TO OTHER STATE, FEDERAL AND/OR LOCAL LAWS, WHICH ARE NOT ENFORCED BY THIS DEPARTMENT THAT MAY NEED TO BE MET SUCH AS: ZONING, BUILDING, SANITATION AND LABOR REQUIREMENTS.*
- b. *I/WE HAVE READ AND UNDERSTAND THE STATUTES AND REGULATIONS WHICH PERTAIN TO MY/OUR LICENSING CATEGORY PRIOR TO THE ISSUANCE OF MY/OUR LICENSE.*
- c. *I/WE SHALL ENSURE THAT ALL PERSONS SUBJECT TO FINGERPRINT REQUIREMENTS SHALL HAVE A CALIFORNIA DEPARTMENT OF JUSTICE CLEARANCE OR A CRIMINAL RECORD EXEMPTION PRIOR TO EMPLOYMENT, RESIDENCE OR INITIAL PRESENCE IN THE ORGANIZATION AS REQUIRED.*
- d. *I/WE SHALL OBTAIN APPROVAL FROM THE DEPARTMENT PRIOR TO MAKING ANY CHANGE(S) THAT AFFECTS THE TERMS OF THE LICENSE.*

15. *I/WE UNDERSTAND THAT I/WE HAVE THE RIGHT TO APPEAL ANY DECISION REGARDING THE DISPOSITION OF THIS APPLICATION.*

16. *I/WE DECLARE UNDER PENALTY OF PERJURY THAT THE STATEMENTS ON THIS APPLICATION AND ON THE ACCOMPANYING ATTACHMENTS ARE CORRECT TO THE BEST OF MY/OUR KNOWLEDGE.*

17. *I/WE AM/ARE AUTHORIZED TO SIGN THIS APPLICATION ON BEHALF OF THE NAMED APPLICANT.*

SIGNED _____ TITLE _____ COUNTY WHERE SIGNED _____ DATE _____

SIGNED _____ TITLE _____ COUNTY WHERE SIGNED _____ DATE _____

APPLICANT INFORMATION (HCS 215)

This form must be completed by all applicants for a Home Care Organization license, (i.e., all individuals, each partner in a partnership, or chief executive officer or authorized representative in a corporation.) If more space is required, attach additional sheet. Type or print clearly.

IDENTIFYING INFORMATION

NAME	SOCIAL SECURITY NUMBER (VOLUNTARY FOR I.D. ONLY)	SEX (M/F)	ARE YOU 18 YEARS OR OLDER?

TITLE	DRIVER'S LICENSE NUMBER/ IDENTIFICATION CARD NUMBER	STATE ISSUED	ALIEN REGISTRATION CARD NUMBER

ADDRESS	AREA CODE/TELEPHONE
	( )

OTHER NAME(S) USED BY APPLICANT

EDUCATION

Circle highest completed grade: 1 2 3 4 5 6 7 8 9 10 11 12

NAME AND LOCATION OF HIGH SCHOOL	DATE COMPLETED	GED DATE

NAME AND LOCATION OF COLLEGE	COURSE STUDY	YEARS COMPLETED	DEGREE	DATE COMPLETED
		1 2 3 4		
		1 2 3 4		

REFERENCES

PERSONAL: *(PLEASE GIVE REFERENCES, INCLUDING PRESENT AND PAST EMPLOYERS, WITH KNOWLEDGE OF YOUR ADMINISTRATIVE ABILITY.)*

NAME	ADDRESS	RELATIONSHIP	AREA CODE/TELEPHONE
1.			( )
2.			( )

FINANCIAL: *(PLEASE GIVE REFERENCES WITH KNOWLEDGE OF FINANCIAL RESOURCES AND BUSINESS PRACTICES.)*

NAME	ADDRESS	RELATIONSHIP	AREA CODE/TELEPHONE
1.			( )
2.			( )

PRIOR LICENSURE STATUS

A. HAVE YOU EVER BEEN A LICENSEE OR CO-LICENSEE OF A LICENSED CLINIC, HEALTH CARE FACILITY, COMMUNITY CARE FACILITY, RESIDENTIAL CARE FACILITY FOR PERSONS WITH CHRONIC LIFE-THREATENING ILLNESS, RESIDENTIAL CARE FACILITY FOR THE ELDERLY, CHILD DAY CARE FACILITY, DAY CARE CENTER, FAMILY DAY CARE HOME, EMPLOYER-SPONSORED CHILD CARE CENTER, OR HOME CARE ORGANIZATION? ☐ YES ☐ NO *IF YES, COMPLETE D AND E BELOW.*

B. HAVE YOU EVER HELD A BENEFICIAL OWNERSHIP OF 10% OR MORE IN COMMUNITY CARE FACILITY, RESIDENTIAL CARE FACILITY, RESIDENTIAL CARE FACILITY FOR THE ELDERLY, CHILD DAY CARE FACILITY, DAY CARE CENTER, FAMILY DAY CARE HOME, EMPLOYER-SPONSORED CHILD CARE CENTER, OR HOME CARE ORGANIZATION OR BEEN AN ADMINISTRATOR, GENERAL PARTNER, CORPORATE OFFICER, OR DIRECTOR OF ANY SUCH FACILITY? ☐ YES ☐ NO *IF YES, COMPLETE D AND E BELOW.*

C. HAVE YOU EVER BEEN REGISTERED WITH THE TRUSTLINE REGISTRY PROGRAM? ☐ YES ☐ NO *IF YES, COMPLETE E BELOW.*

D. NAME AND ADDRESS OF FACILITY	EFFECTIVE DATES OF LICENSURE _____ TO _____	FACILITY TYPE

E. WERE ANY DISCIPLINARY ACTIONS TAKEN? ☐ YES ☐ NO *IF YES, PLEASE EXPLAIN:*

BUSINESS EXPERIENCE

A. HAVE YOU OWNED OR OPERATED ANY BUSINESS? ☐ YES ☐ NO *IF YES, PLEASE COMPLETE THE FOLLOWING:*

Type	Number of Employees	Your Title	Date Started	Date Ended	Reason for Leaving

B. DO YOU HAVE A PROFESSIONAL LICENSE OR CERTIFICATE? ☐ YES ☐ NO *IF YES, PLEASE COMPLETE THE FOLLOWING:*

Type	Period Held	Issuing Agency

WORK EXPERIENCE. BEGIN WITH YOUR MOST RECENT WORK EXPERIENCE. LIST ALL EXPERIENCES AND PERIODS OF UNEMPLOYMENT IN THE LAST SEVEN YEARS. INCLUDE WORK EXPERIENCE FROM MORE THAN SEVEN YEARS, IF NECESSARY.

Dates	Name and Address of Employer	Basic Duties	Reason for Leaving
FROM			
TO			
FROM			
TO			
FROM			
TO			
FROM			
TO			
FROM			
TO			
FROM			
TO			

I DECLARE UNDER PENALTY OF PERJURY THAT THE STATEMENTS ON THIS FORM ARE CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE	COUNTY WHERE SIGNED	DATE

Federal law (at Title 5 United States Code Section 552a Note) states that: Any Federal, State, or local government agency which requests an individual to disclose his social security account number shall inform that individual whether that disclosure is mandatory or voluntary, by what statutory or other authority such number is solicited, and what uses will be made of it.

DESIGNATION OF HOME CARE ORGANIZATION RESPONSIBILITY (HCS 308)

Licensed Home Care Organizations are required to have an authorized person continuously present during business hours to represent the Home Care Organization and to accept licensing reports. Licensees shall use this form to delegate the above authority to appropriate staff. Applicants/licensees who are corporations shall attach board resolutions authorizing this delegation.

DATE	HOME CARE ORGANIZATION NAME		HOME CARE ORGANIZATION NUMBER	
HOME CARE ORGANIZATION ADDRESS		CITY	STATE	ZIP CODE
COUNTY		AREA CODE/TELEPHONE ( )		
NAME OF DESIGNEE				

In the event of my absence I authorize the abovementioned person to receive any documents including reports of inspections and consultations, accusations and civil and administrative processes on my behalf at the above-named Home Care Organization.

When delegating authority to appropriate staff, Home Care Organizations shall comply with CCR Title 22, Division X Section XXXXX.

I (We) shall notify the licensing agency, in writing, within 10 days of any change in the above authorization.

SIGNATURE OF APPLICANT/LICENSEE				
NAME OF APPLICANT/LICENSEE		TITLE		
ADDRESS	CITY	COUNTY	STATE	ZIP CODE

EMPLOYEE DISHONESTY BOND (HCS 402)

APPLICANT/LICENSEE NAME			
APPLICANT/LICENSEE ADDRESS	CITY	STATE	ZIP CODE
BONDING COMPANY			AREA CODE/TELEPHONE ( )
BONDING COMPANY ADDRESS	CITY	STATE	ZIP CODE
LOCAL AGENT NAME			AREA CODE/TELEPHONE ( )

The addresses shown above for licensee and Bonding Company will be used for service of notices, papers, and other documents.

BE IT KNOWN THAT:

Licensee, as Principal, and Bonding Company, as Surety, are held and firmly bound to the State of California and the clients, which includes current, former, and potential clients, of the Home Care Organization, as beneficiary, in the amount of $_____ (_____) for the payment of which the principal and surety bind themselves, their respective heirs, successors and assigns, jointly and severally.

WHEREAS Health and Safety Code section 1796.42 requires certain applicants for licenses to file and maintain with the California Department of Social Services a surety bond; and

WHEREAS the licensee has applied to operate a Home Care Organization;

NOW, THEREFORE, the surety is liable on this bond in the event that the principal fails to handle faithfully and honestly the money of Home Care Organization clients.

The Home Care Organization covered by this bond is:

HOME CARE ORGANIZATION NAME			
HOME CARE ORGANIZATION ADDRESS	CITY	STATE	ZIP CODE
HOME CARE ORGANIZATION LICENSE NUMBER	*NOTE:* IF OTHER HOME CARE ORGANIZATIONS ARE COVERED BY THIS BOND, SPECIFY ON A SEPARATE, ATTACHED PAGE THE NAME, ADDRESS, HOME CARE ORGANIZATION LICENSE NUMBER, AND THE BOND AMOUNT FOR EACH HOME CARE ORGANIZATION		

Every person injured as a result of any unfaithful or dishonest handling of client money or property may bring an action in a proper court on the bond for the amount of damage suffered thereby to the extent covered by the bond.

The aggregate liability of the Surety for all claims against this bond shall not exceed the amount of the bond, shown above.

This bond may be canceled by the Surety in accordance with Code of Civil Procedure section 996.030, and notice of cancellation must be sent in accordance with Code of Civil Procedure section 996.320. This bond is effective _____, and remains in effect as long as the license is valid.
DATE

I certify under penalty of perjury under the laws of the State of California that the information provided on this page and on any attachments is true and correct.

BONDING COMPANY SIGNATURE:	BOND NUMBER:	DATE:

HOME CARE ORGANIZATION PERSONNEL REPORT (HCS 500)

INSTRUCTIONS: *This form is intended* to provide the Department with a list of *all facility personnel, including volunteers and licensee. Report any changes in personnel to the licensing agency as required by Health and Safety Code Section 1796.43. Send original to the Department and retain copy in the Home Care Organization file.*

HOME CARE ORGANIZATION REQUIREMENTS: The Home Care Organization must ensure anyone who has contact with clients, prospective clients, or confidential client information has met the following requirements pursuant to Section 1796.43 of the Health and Safety Code. Documentation must be kept in personnel file for department review.

HOME CARE ORGANIZATION NAME	PREPARED BY	DATE
HOME CARE ORGANIZATION NUMBER	TYPE ☐ INITIAL APPLICATION ☐ RENEWAL APPLICATION	

NAME OF EMPLOYEE/VOLUNTEER	DATE EMPLOYED	POSITION	CRIMINAL BACKGROUND CHECK CLEARANCE/ EXEMPTION	LISTED ON THE HCA REGISTRY (Y/N)	TUBURCULOSIS TEST			TRAINING REQUIREMENTS (Enter hours in applicable column)	
					DATE OF TB TEST	RESULT (N/P)	ACTION TAKEN (IF POSITIVE)	ENTRY LEVEL TRAINING	*ANNUAL TRAINING

SIGNATURE	NAME (PRINT)	DATE

PERSONNEL RECORD (HCS 501)

(Form to be completed by employee at the time of hire)

DATE
NAME OF HOME CARE ORGANIZATION
HOME CARE ORGANIZATION ADDRESS
HOME CARE ORGANIZATION NUMBER

PERSONAL

NAME (LAST FIRST MIDDLE)	AREA CODE/TELEPHONE ( )
ADDRESS	DATE OF BIRTH

SOCIAL SECURITY NUMBER: (VOLUNTARY FOR ID ONLY)	DATE OF LAST TB TEST	RESULTS OF LAST TB TEST

HAVE YOU EVER BEEN EMPLOYED UNDER A DIFFERENT NAME? ☐ YES ☐ NO IF YES, PLEASE LIST ALL NAMES USED:

DO YOU POSSESS A VALID CALIFORNIA DRIVER'S LICENSE? ☐ YES ☐ NO

CDL NUMBER: _____

HAS YOUR DRIVER'S LICENSE EVER BEEN SUSPENDED OR REVOKED? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN ON A SEPARATE SHEET OF PAPER AND ATTACH TO THIS FORM.

POSITION INFORMATION

TITLE OF POSITION	TIME BASE

EMPLOYMENT

(List most recent experience first. If additional space is needed, please attach a separate page.)

NAME AND ADDRESS OF EMPLOYER	AREA CODE/ TELEPHONE	JOB TITLE AND TYPE OF WORK	REASON FOR LEAVING	DATES FROM	DATES TO
	( )				
	( )				
	( )				
	( )				
	( )				

Notes:

I hereby certify under penalty of perjury that the above statements are true and correct. I give my permission for any necessary verification.	
EMPLOYEE SIGNATURE:	DATE:

Next Steps

References

- Home Care Services Bureau

  http://www.ccld.ca.gov/PG3654.htm
- Caregiver Background Check Bureau

  http://www.ccld.ca.gov/PG399.htm
- Health and Safety Code
  http://leginfo.legislature.ca.gov/faces/codes_displayexpandedbranch.xhtml

Acronyms

Acronym	Term
AB	Assembly Bill
CBCB	Caregiver Background Check Bureau
CCLD	Community Care Licensing Division
CDSS	California Department of Social Services
DOJ	Department of Justice
EM	Evaluator Manual
FAQ	Frequently Asked Questions
H&SC	Health and Safety Code
HCA	Home Care Aide
HCO	Home Care Organization
HCS	Home Care Services
HCSB	Home Care Services Bureau
HCSCPA	Home Care Services Consumer Protection Act
LPA	Licensing Program Analyst
RO	Regional Office
TL	TrustLine

Contact Us

For more information regarding the Home Care Services Consumer Protection Act, please contact the Home Care Services Bureau by e-mail at HCSB@dss.ca.gov or by telephone at (916) 657-2592.